DR. MICHAEL J. COHN
Optometrist

TO: Sarah Iselin, Commissioner, Division of Health Care Finance and Policy

FROM: Michael J. Cohn, O.D., President, Massachusetts Society of Optometrists

DATE: April 3, 2009

RE: A New Blended Healthcare Initiative: Reducing Costs While Increasing Access

Please accept the enclosed proposal for a new blended healthcare initiative to improve healthcare in Massachusetts. This proposal will define this program, describe ways of paying for it and means for building a consensus of support. As an optometrist in private practice and the current President of the Massachusetts Society of Optometrists (MSO), I have a unique insight into the delivery of health care in Massachusetts.

I would like to propose a new blended healthcare system which would utilize the uniform standard regulations of a single payer system while benefiting from the competitive market forces of a consumer-driven open marketplace. In blending the best qualities of these two systems, all providers would have to accept a uniform base fee procedure rate for lower income individuals. Providers would also have the option to choose to balance bill all other subscribers the difference in fees up to a maximum allowable amount. Health insurance and maintenance organizations would continue to compete and administer this program. They would have to work within the same framework of uniform procedure codes, base fees, utilization, and PQRI protocols as well as allow open access to all licensed providers of approved services. Base fees could be set at various levels in order to help control over utilization of specific procedures.

If you have any questions or concerns, please do not hesitate to contact me at (508) 832-9392 or by e-mail at drlucohn@aol.com. I appreciate your consideration of this proposal and look forward to speaking with you at your earliest convenience.

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A New Blended Healthcare Initiative: Reducing Costs While Increasing Access

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Overview: Containing the rapid growth of healthcare spending while improving access to care through the development of a transparent blended healthcare delivery system

Massachusetts faces a challenge in requiring all citizens to have health insurance in the face of rising cost for that care. Massachusetts has a *per capita* healthcare cost that is 30% above the national average.[1] One of the causes of this cost of care is the inequity in provider fees, especially those provider networks associated with major teaching hospitals as referenced in a November 16, 2008 *Boston Globe* article "*A Healthcare System Badly out of Balance.*"

Massachusetts, through its universal health plan called Commonwealth Health Connector, attempts to subsidize income–eligible citizens with health insurance offered through selected health plans.[2] The idea was that cost containment would be attempted through creating limited networks of providers. Often comprised of the most expensive provider networks in the state, these networks were meant to maintain quality, but, had the ancillary effect of reducing access to care. Concurrently, other private HMOs, utilizing capitation plans in order to control costs, provide larger reimbursements when fewer services are offered. The Commonwealth's attempt to increase access would appear to actually have reduced it while increasing costs.

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[1] Miltenberger, Michael et al, Massachusetts Healthcare Reform: A Framework for Evaluation. January 2009. http://www.pioneerinstitute.org/pdf/090116_pb_poftak_reform.pdf

[2] Chapter 58 of the Acts of 2006

This is not surprising. Historically, capitation and limited access plans have generally failed in Massachusetts and elsewhere since their introduction to the marketplace. Many of these plans that exist today actually inflate costs. For example, the Medicare Advantage plans represent about 14% more than traditional fee-for-service Medicare coverage according to estimates by the Congressional Budget Office.[3] Single payer systems in Europe and Canada spend approximately 9% to 10% of GNP on healthcare costs as compared to 17% in the United States.[4] This is not to say single payer systems are the answer. Developing a single payer government healthcare system in the United States with increased access to care is unrealistic due to the heavy privatization of our present healthcare system. In order to improve healthcare in Massachusetts a new transparent blended system must be implemented.

Explanation of Proposed Solutions:

The Insurance Commissioner of Massachusetts must enforce open and non-discriminatory regulations for all health insurance companies. All health insurance companies that compete for business in Massachusetts must accept:

1) Open access to all licensed providers for urgent, preventative, and follow-up care. Many countries with superior healthcare quality and significantly lower costs than the United States utilize open access to all licensed healthcare providers.[5]
2) A transparent relative value equation for determining the base cost of services, irrespective of the discipline of licensed provider or the type of institutions that render such services (similar to the Medicare relative value provider fee schedule).
3) The ability of the Commissioner of Insurance to regulate base relative value costs dependent on additional variables, such as Physician Quality Reporting Initiative (PQRI), pay-for-performance quotients, teaching hospitals, research environments, general health care needs, and overall state economic

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[3] Connolly, Ceci. *Budget would reserve $634b for Healthcare.* Boston Globe. 2/26/2009.

[4] Health Insurance Costs. National Coalition on Health Care. 2009. http://www.nchc.org/facts/cost.shtml

[5] Boufford, Jo Ivey. European Health Care Reform and Primary Care. The National Academies Press. 1994. http://books.nap.edu/openbook.php?record_id=9218&page=31.

determinations. Rates may be raised to increase utilization of procedures deemed necessary for improved overall health outcomes. In addition, rates may be reduced to help control over utilization of procedures that do not have proven positive outcomes. Rates shall be set in consultation with vested interest groups and consumer advocates – with an emphasis on facts and transparency.

4) A prerequisite to allow providers and institutions (in a non-discriminatory way) to:

    a. Accept—as Preferred Providers—the base rates provided by the Insurance Commission as payment in full. Since Medicare rates in Massachusetts presently run 30% to 50% less than private insurance provider fee rates, any base relative value fee near or moderately above the Medicare rate would represent a huge cost reduction in health insurance premiums.

    b. Alternatively, accept—as General Providers—the established base rates with the ability to then balance bill the subscriber the difference between the base rate and the maximum contracted allowable rate that insurance companies and HMOs have established via state approved contracts to administer such programs. General Providers shall accept as payment in full the base rate for low-income patient groups as defined by the newly created Commonwealth Health Insurance Connector (ensuring affordability to those most in need). General Providers may choose to balance-bill all other patient groups up to the negotiated allowable amounts. General Providers may also contract to have the option to balance-bill a percent of the difference between the base rate and the maximum allowable amount. Insurance companies will be obligated to advertise to subscribers the different levels of approved providers. (Note: transparency within the system will ensure that consumers, educated as to rates, will also ensure balance billing does not become an exhorbitant "out-of-pocket" expenditure.) The overall provider fee reduction realized by insurance companies shall then be redistributed as lower premiums, additional premium subsidies for low-income groups, and additional income to primary care providers in order to increase the number of primary care providers in Massachusetts. In addition, base provider rate

fees could be lower for low-income group health insurance policies, but proportionately higher for all other groups. In this way increased monetary solvency for universal coverage could be obtained.

5) The ability to negotiate and establish published, maximum-allowable provider fees when establishing limited balance billing protocols.
6) The standardization of uniform procedure codes that would be utilized by all licensed providers of those services. While this is currently being studied, its implementation would be uniformly sped up in concert with the aforementioned items.
7) Published and approved standard-of-care utilization protocols for all medical and surgical procedures. Procedures falling outside these protocols would require prior authorization for allowable insurance coverage. Procedures that are not a covered service would be subject to out-of-pocket expense by subscribers.
8) The ability to compete based on transparent utilization data, computerized monitoring of utilization protocols, efficiencies of business administration, the creation of new management teams for the chronically ill and overall management of patient care and outcomes. In this way utilization and associated costs would be controlled by open and innovative competition among private insurance companies. Health insurance companies would thus be freed from the diversion of the politics of fee negotiations and could concentrate on their mission to manage health care.
9) Government must mandate that all insurance and HMO savings from regulated fees pass directly to consumers as reduced premiums and additional revenue to primary care providers. This could be delegated and enforced by the Insurance Commissioner as part of insurers' annual filing requirements. In addition, savings could be transferred to a special government account to be used for increased subsidies to the Commonwealth Health Insurance Connector's health insurance clients.
10) Added financial incentives and increased income levels must be established to encourage providers to enter primary care fields. Primary care services are our first line of defense in preventing disease. To achieve such incentives, all private and government programs must accept the Insurance Commissioner's required

coding initiatives that additionally describe urgent care visits and related primary care administrative costs.

Start Up Costs:

The Commissioner of Insurance would incur the cost associated with implementing a transparent blended healthcare delivery system. A council of overseers would be needed to assure all regulations are carried out in a transparent fashion. Committees would be needed to establish written uniform utilization protocols, standards of care and procedure coding. The costs of implementation would be minimal compared to the cost savings recognized within a regulated and blended free market, private health insurance landscape. Funding for such a program should come from within the Massachusetts Federal Medicaid waiver allotment, the federal government's stimulus package, and the Massachusetts General Fund.

The establishment of this blended healthcare system would only require an executive order from the Governor and regulations promulgated by the Insurance Commissioner. Additional regulations could be created and enforced by the newly created Massachusetts Healthcare Quality and Cost Council. The ability to perfect this proposal may require legislative action.

Positive Outcomes Generated:

Massachusetts residents and businesses would immediately see a reduction of health insurance premiums or, at the very least, a greatly reduced inflationary rate of premiums. This plan would end the unfair disparity in provider fees – essentially creating an inherent efficiency whereby providers would be inclined to treat to the higher levels of their scope of practice. A result of such disparity is that more expensive provider networks—which demand highly inflated fees—are essentially subsidized by greatly increased premiums to all citizens throughout Massachusetts.

In addition, this plan will offer a rational and transparent formula for determining fair provider fees. The concept of limited balanced billing would allow those providers who choose to be General Providers the potential to receive higher reimbursements due to consumer market perceptions of higher value and quality. Those providers choosing Preferred Provider status would benefit from the promotion and potential of increased volume of patients and market share. Providers who develop the most efficient business and management skills would benefit the most. Additional incentives should be offered to encourage providers to accept preferred provider status. In return for long-term contracts, preferred providers should be offered large stipends for the purchase of electronic record systems available through the new federal government's stimulus package.

Consumers would benefit from additional choices among different perceived and real levels of services. These benefits would exist alongside the economic stability and inclusion of low-income groups in universal healthcare. Open and free market forces would determine perceived top end monetary value and quality of care proclamations by various provider groups. This plan would greatly increase access to preventative, urgent and follow up care while controlling cost and improving the overall health of our citizens – through the creation of both consumer and provider behavioral incentives.

Nationally, each state could implement a similar blended health care system to allow for universal healthcare. It may be possible to offer limited balance billing practices in the Medicare program especially as it may apply to medium and upper income groups. This may allow for the reduction of certain Medicare provider fees and thus overall Medicare cost containment.

Current Practices:

Large expensive provider practices in Massachusetts have been able to negotiate fees up to 40% greater than other physician and provider groups throughout the state. According to the Boston Globe Spotlight Team Series, a two percent increase in HMO premiums per year for all citizens was needed for a total three-year fee increase of six percent, provided

to an exclusive group of 22% of the physicians in Massachusetts.[6] If fees for expensive groups were to be reduced to the same base rate as the current HMO rate for all other physicians, then corresponding savings of approximately 15% would be realized. If the base rates for all providers were set closer to the present Medicare rates then savings totaling 30% or more could be obtained. There is no reasonable rationale for the current fee disparity.

Provider negotiations in Massachusetts are now based on the 'largest carrot' concept. Those provider groups that have the largest carrot (control of a given market) have the most influence in negotiations with insurance companies. All negotiations are secret and supporting data are kept private. The ability to establish uniform base fees for all providers has proven to be successful with the present Medicare system and indeed represents a much lower fee as compared to private insurance companies.

Furthermore, Massachusetts HMO's do not actively promote or require providers to adhere to written uniform utilization protocols for medical procedures. This state of confusion leads to over-utilization and significantly higher costs. Requiring HMO's to provide providers with uniform written protocols (similar to Medicare requirements) and requiring providers to adhere to such protocols would increase cost containment.

Future Goals:

A coalition of like-minded groups would be needed to move this idea forward. Organized support for a blended healthcare system could come from primary care physician groups, the Academy of Family Practice, the Association of Nurse Practitioners, the Association of Community Hospitals, various business and industrial groups, labor organizations, advocacy groups servicing underserved populations, and healthcare insurance companies concerned with controlling costs. Insurance companies should welcome the idea of competing on a level playing field and competing in areas of information management, health management, and business efficiency. Many specialty and sub-specialty physicians

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[6] Allen, Scott, Bombardieri, Marcella. A healthcare system badly out of balance. The Boston Globe. November 16, 2008.

would welcome the idea of limited balanced billing within regulatory guidelines. All providers would welcome a fair transparent formula for determining fee structure in a non-discriminatory manner. Government agencies would be allowed to regulate uniform fee structures for the purpose of controlling utilization in order to obtain appropriate care and cost control. Most importantly, citizens of all economic levels will have maximum access for continual care from their local providers in their communities.

It is time to lead the healthcare reform movement with the implementation of a blended system. Massachusetts residents and businesses can no longer afford the status quo. To improve cost containment and reduce costs, the Commonwealth must implement a plan that incentivizes both consumers and providers to seek efficiencies in the provision of health care.